



Application for Retired Member Change of Beneficiary and/or Retirement Option

State Form 49518 (R3/3-04)
Approved by the State Board of Accounts 2004

Indiana State Teachers' Retirement Fund
150 West Market Street, Suite 300
Indianapolis, IN 46204-2809
Telephone: (317) 232-3860 / (888) 286-3544
Home Page: <http://www.in.gov/trf>

PRIVACY NOTICE

Your Social Security number is requested by this agency in accordance with the requirements of IRS Code 3405. Disclosure is mandatory; this form will not be processed without this information.

PART 1: RETIRED MEMBER INFORMATION

Name of retired member (<i>first, middle, last</i>)	TRF Number	Social Security number
Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Area code and telephone number () -	Date of birth
	Is this a new address? <input type="checkbox"/> YES	

PART 2: REELECTION OF BENEFITS

Please be sure to mark your selection "Yes" or "No" for the A-4 option (*Social Security integration*) if you are under age 62. If "Yes", you must enclose a copy of your Social Security Estimate.

- ☐ A-2 Straight life without a guaranteed period
With A-4 Yes ☐ No ☐
- ☐ B-1 100% Survivorship
With A-4 Yes ☐ No ☐
- ☐ B-2 66 2/3% Survivorship
With A-4 Yes ☐ No ☐
- ☐ B-3 50% Survivorship
With A-4 Yes ☐ No ☐

IF YOU HAVE SELECTED ANY OF THE "B" OPTIONS, YOU MUST DESIGNATE A CO-SURVIVOR IN THE SPACE THAT FOLLOWS AND PROVIDE A COPY OF THE CO-SURVIVOR'S BIRTH CERTIFICATE.

Name of Co-Survivor	Date of Birth	Social Security number
Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	TRF number (<i>if co-survivor is a member</i>)	Relationship

IF YOU WANT LUMP SUM PAYMENT WHICH MIGHT BE DUE AT YOUR DEATH TO GO TO SPECIFIC BENEFICIARIES RATHER THAN TO YOUR ESTATE, PLEASE SELECT BENEFICIARIES BELOW.

Name of beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Social Security Number	Name of beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Social Security Number
Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Date of Birth	Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Date of Birth
	Relationship		Relationship

Name of beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Social Security Number	Name of beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Social Security Number
Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Date of Birth	Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Date of Birth
	Relationship		Relationship

Name of beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Social Security Number	Name of beneficiary <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Social Security Number
Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Date of Birth	Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Date of Birth
	Relationship		Relationship

PART 3: NOTARIZATION

I swear that I am the above named applicant; that I have personally prepared the foregoing application; and that I have carefully read the questions and answers thereto and understand the same; that each answer is full, complete and true; no material fact has been concealed or omitted therefrom; and that said answers are made for presentation to the Board of Trustees of the Indiana State Teachers' Retirement Fund in making claim for a retirement benefit that may be payable to me under Indiana Code, section 5-10.2 and Indiana Code, section 21-6.1. I hereby revoke all beneficiaries and/or retirement options previously selected by me, and hereby select the above beneficiary designations and/or retirement option. I have furnished all necessary documentation (marriage license, death certificate of first spouse, and birth certificate of new beneficiary) as required. I understand that any modifications in either my retirement option or beneficiary designation may result in a significant change in my monthly benefit.

Date Signed (<i>month day, year</i>)	Printed name of retired member
Retired Member's Full Address (<i>street or P.O. Box, city, state, ZIP code</i>)	Signature of retired member

Signature of Notary Public	Printed name of Notary Public
Notary Public's County of Residence	Commission Expiration Date

Please mail as soon as possible to: **Indiana State Teachers' Retirement Fund**
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Indianapolis, IN 46204-2809